FORM B10 (Official Form 10)(4/98)

UNITED STATES BANKRUPTCY COURT
DISTRICT OF IDAHO (BOISE)

DISTRICT OF IDAHO
FILED AT _____
JUL 2 1999
Deputy

PROOF OF CLAIM

Name of Debtor	Case Number
Dale Blush Leona Blush	99-01784

NOTE: This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A "request" for payment of an administrative expense may be filed pursuant to 11 U.S.C. §503

Name of Creditor (The person or other entity to whom the debtor owes money or property):
Mercy Hospital
Name and Address where notices should be sent:

Mercy Hospital
1512 12th Avenue Road
Nampa, ID 83686

Telephone Number:

- ☐ Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.
- ☐ Check box if you have never received any notices from the bankruptcy court in this case.
- ☐ Check box if the address differs from the address on the envelope sent to you by the court.

99-01784

1250030

THIS SPACE IS FOR COURT USE ONLY

Account or other number by which creditor identifies debtor:

Check here if this claim ☐ replaces ☐ amends a previously filed claim, dated _____

1. Basis for Claim
- ☐ Goods sold
- ☐ Services performed
- ☐ Money loaned
- ☐ Personal injury/wrongful death
- ☐ Taxes
- ☐ Other _____

- ☐ Retiree benefits as defined in 11 U.S.C. §1114(a)
- ☐ Wages, salaries, and compensation (fill out below)
  Your SS #: _____ _____ _____
  Unpaid compensation for services performed
  from _____ (date) to _____ (date)

2. Date debt was incurred:

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $_____
If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.
☐ Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.

5. Secured Claim.
☐ Check this box if your claim is secured by collateral (including a right of setoff).
Brief Description of Collateral:
☐ Real Estate ☐ Motor Vehicle
☐ Other_____

Value of Collateral: $_____

Amount of arrearage and other charges at time case filed included in secured claim, if any: $_____

6. Unsecured Priority Claim.
☐ Check this box if you have an unsecured priority claim
Amount entitled to priority $_____
Specify the priority of the claim:
- ☐ Wages, salaries, or commissions (up to $4,300),* earned within 90 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(3).
- ☐ Contributions to an employee benefit plan - 11 U.S.C. §507(a)(4).
- ☐ Up to $ 1,950* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(6).
- ☐ Alimony, maintenance, or support owed to a spouse, former spouse, or child - 11 U.S.C. § 507(a)(7).
- ☐ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8).
- ☐ Other - Specify applicable paragraph of 11 U.S.C. § 507(a)(__).

**Amounts are subject to adjustment on 4/1/01 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

7. Credits: The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.

8. Supporting Documents: *Attach copies of supporting documents,* such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.

9. Date-Stamped Copy: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

THIS SPACE IS FOR COURT USE ONLY

(3)

Date	Sign and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any):

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

Chapter 12 and 13 claims, along with any supporting must be filed in duplicate.

000963

CATHOLIC HEALTH INITIATIVES

Mercy Medical Center

PATIENT	PT TYPE
BLUSH,DALE E	LX

ACCOUNT NUMBER	DATE ADMITTED	DATE DISCHARGED
9733000256	11/28/97	11/28/97

BILL DATE 12/03/97

STMT TYPE D1 BILLER 3

450001 REGENCE BLUE SHIELD IDAHO (M)
450002 REGENCE BLUE SHIELD OF IDAHO 1500

☐ MASTER CARD ☐ VISA ☐ DISCOVER ☐ AMEX

CARD NO. _____ EXP. DATE _____

SIGNATURE _____ PAYMENT AMOUNT $ _____

GUARANTOR:

DALE E BLUSH
1780 E OVERLAND RD #45
MERIDIAN ID 83642-6610

MERCY MEDICAL CENTER
DEPARTMENT 532
PO BOX 34935
SEATTLE WA 98124-1935
1-208-463-5038

PLEASE ENCLOSE THIS PORTION WITH YOUR PAYMENT AND WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK

SERVICE DATE	UB92-REV	ITEM NO.	DESCRIPTION	QTY	ITEM PRICE	TOTAL CHARGES
			350 CT SCAN			595.00
			TOTAL CHARGES			595.00
12/31/97	368	I1511	BLUE SHIELD OF IDAHO		236.00CR	
			TOTAL PAYMENTS/ADJUSTMENTS			-236.00

NOTE: THIS BALANCE DOES NOT INCLUDE PROFESSIONAL CHARGES FOR PHYSICIANS SUCH AS EMERGENCY PHYSICIANS, ANESTHESIOLOGISTS, RADIOLOGISTS, PATHOLOGISTS AND CARDIOLOGISTS. YOU WILL RECEIVE A SEPARATE BILL DIRECTLY FROM THE PHYSICIAN FOR THOSE SERVICES.

ACCOUNT BALANCE 359.00

S

STATEMENT OF ACCOUNT

CATHOLIC HEALTH INITIATIVES

Mercy Medical Center

PATIENT:		PT TYPE
BLUSH,DALE E		LX
ACCOUNT NUMBER	**DATE ADMITTED**	**DATE DISCHARGED**
9733000256	11/28/97	11/28/97

BILL DATE 12/03/97

STMT TYPE D1 BILLER 3

450001 REGENCE BLUE SHIELD IDAHO (M)
450002 REGENCE BLUE SHIELD OF IDAHO 1500

☐ MASTER CARD ☐ VISA ☐ DISCOVER ☐ AMEX

CARD NO. _____ EXP. DATE _____

SIGNATURE _____ PAYMENT AMOUNT $ _____

GUARANTOR:

DALE E BLUSH
1780 E OVERLAND RD #45
MERIDIAN ID 83642-6610

MERCY MEDICAL CENTER
DEPARTMENT 532
PO BOX 34935
SEATTLE WA 98124-1935
1-208-463-5038

PLEASE ENCLOSE THIS PORTION WITH YOUR PAYMENT AND WRITE YOUR ACCOUNT NUMBER ON YOUR CHECK

SERVICE DATE	UB92-REV	ITEM NO.	DESCRIPTION	QTY	ITEM PRICE	TOTAL CHARGES
			350 CT SCAN			595.00
			TOTAL CHARGES			595.00
12/31/97	368	I1511	BLUE SHIELD OF IDAHO		236.00CR	
			TOTAL PAYMENTS/ADJUSTMENTS			-236.00

NOTE: THIS BALANCE DOES NOT INCLUDE PROFESSIONAL CHARGES FOR PHYSICIANS SUCH AS EMERGENCY PHYSICIANS, ANESTHESIOLOGISTS, RADIOLOGISTS, PATHOLOGISTS AND CARDIOLOGISTS. YOU WILL RECEIVE A SEPARATE BILL DIRECTLY FROM THE PHYSICIAN FOR THOSE SERVICES.

ACCOUNT BALANCE 359.00

STATEMENT OF ACCOUNT

S